SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
Individual Rehabilitation Supports Plan

Please Type or Print

Name:	Medicaid #:

My Goal is to improve or retain skills in the following area:

☐ Personal Care	☐ Cognitive/independent living skills	☐ Health and Nutrition
☐ Self-esteem	☐ Personal Responsibility	☐ Coping Skills
☐ Medication Management	☐ Social Skills	☐ Community Living

My objective for reaching my goal in the area noted above is:

Personal Care:

Cognitive/independent living skills:

Health/Nutrition:

Self-esteem:

Personal Responsibility:

Coping Skills:

Medication Management:

Social Skills:

Community Living:

These activities will help me accomplish my objective:

I plan to work on this objective: times weekly times monthly

I plan to accomplish this objective by (month/year):

Date Services to Begin: 6 month Review Due Date:

Person:

Parent/Guardian (if person is a minor):

Lead Clinical Staff:

6 month Review

Progress made toward accomplishing goal/objective? ☐ Yes ☐ No

Issues pertinent to functioning:

Continue Rehabilitation Supports? ☐ Yes ☐ No

LCS Signature: _____ Date: _____

IRSFORM 3.b